Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

GARY S. WHITING
8607 WURZBACH , V-104
SAN ANTONIO, TX 78240

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-2119-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Preauthorized sessions billed against the accepted compensable injury per insurance guidelines for CPT 96152."

Amount in Dispute: $600.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… Nevertheless, the treatment is unrelated."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. HWY 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 8, 2010, July 22, 2010, August 12, 2010, September 16, 2010 and October 15, 2010	96152	$600.00	$**0.00**

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 relates to MDR-General.
2. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
3. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.

4. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 8, 2010, October 13, 2010, November 5, 2010, December 2, 2010 and December 6, 2010

   - CAC-W4 – No additional reimbursement allowed after review of appeal/reconsideration.
   - CAC-219 – Based on Extent of Injury (NOTE: to be used for workers compensation only).
   - 246 – The treatment/service has been determined to be unrelated to the extent of injury. Final adjudication has not taken place.
   - 891 – No additional payment after reconsideration.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly.
   - CAC-W1 – Workers Compensation State Fee Schedule adjustment.
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.

Issues

1. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Is the requestor eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. The requestor filed a dispute with the Medical Fee Dispute Resolution section at the Division on February 25, 2011. According to 28 Texas Administrative Code §133.305(a)(4), a medical fee dispute is a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) goes on to state that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(H) requires that if the carrier has raised a dispute pertaining to compensability, extent of injury, or liability for the claim, the Division shall notify the parties of the review requirements pursuant to §124.2 of this title, and will dismiss the request until those disputes have been resolved by a final decision, inclusive of all appeals." The appropriate dispute process for unresolved issues of compensability, extent and/or liability requires filing for a Benefit Review Conference pursuant to 28 Texas Administrative Code §141.1 prior to requesting medical fee dispute resolution. No documentation was submitted to support that the issue(s) of compensability, extent and/or liability have been resolved as of the undersigned date.
2. The requestor has failed to support that the services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning liability for the injured employee's workers' compensation claim, compensability of that claim, and/or extent-of-injury issues with that claim have been resolved through the Texas Labor Code Chapter 410 dispute resolution processes, as required, prior to any medical fee dispute for the services being considered. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute and, as a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 8, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.